

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-15-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits, gait training, manual therapy technique, therapeutic exercises, and electrical stimulation from 5-17-04 through 8-30-04 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-9-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 97140 for date of service 5-19-04 was denied by the Carrier with a "D" denial code. Pursuant to Rule 133.304(c) the carrier did not specify which service code 97140 was a duplicate to. Neither party submitted original EOB's. Therefore, these services will be reviewed in accordance with the Medicare Fee Guidelines. **Reimbursement is recommended in the amount of \$33.91.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for date of service 5-19-04 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 15th day of December 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS
[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-0543-01
Name of Patient:	
Name of URA/Payer:	Dashwood Health & Rehab
Name of Provider: (ER, Hospital, or Other Facility)	Dashwood Health & Rehab
Name of Physician: (Treating or Requesting)	John T. Mai, DC

November 30, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the

special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence, examination and treatment records from the provider.
2. Reports and treatment records from Triet Huynh, M.D.
3. Reports and treatment records from Jose Rodriguez, M.D.
4. Examination report from Quynh Bui, D.C.
5. Designated doctor examination by Prisco Evangelista, M.D.
6. Neurological Evaluation by Thai Duc Nguyen, M.D.
7. MRI Report

Patient underwent physical medicine treatments and three epidural steroidal injections after injuring his lumbar spine at work on ____ when he lifted heavy sheet metal.

REQUESTED SERVICE(S)

Office visits (99213); gait training (97116); manual therapy technique (97140); therapeutic exercise (97110); electrical stimulation (97032) from 05/17/04 through 08/30/04.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

No treatment records were available for review during the time period immediately preceding the treatment in question. Therefore, it is unknown what kinds of therapies and/or treatments had been attempted, what was beneficial and what was not, and were the disputed treatments different or more of the same? Without treatment records documenting that the prior care was effective, the medical necessity for continuing treatment is not supported. The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*¹ Chapter 8 under

"Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." In this case, that time frame had long since passed.

A study published in *Spine*² reported that chiropractic spinal manipulation yielded the best results for chronic spinal pain, the *British Medical Journal*³ reported that spinal manipulation combined with exercise yielded the greatest benefit and the AHCPR⁴ guidelines reported that spinal manipulation is the only treatment that can relieve symptoms, increase function and hasten recovery for adults with acute low back pain. In this

¹ Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

² Giles LGF, Muller R. Chronic Spinal Pain - A Randomized Clinical Trial Comparing Medication, Acupuncture, and Spinal Manipulation. *Spine* 2003; 28:1490-1503.

³ Medical Research Council, *British Medical Journal* (online version) November 2004.

⁴ Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.

case, the medical records indicate that a proper regimen ⁵ (only performed on 06/04/004, 06/21/04 and 07/16/04) of spinal manipulation was not performed. The absence of the manipulation code modifier (-MP) and the absence of the manipulation code 98940 also indicate that a proper regimen of chiropractic manipulative therapy was performed. Therefore, based on CPT ⁶, there is no support for the medical necessity for a high level of E/M service (99213) on each and every visit during an established treatment plan.

It is the position of the Texas Chiropractic Association ⁷ that it is beneficial to proceed to the rehabilitation phase (if warranted) as rapidly as possible, and to minimize dependency upon passive forms of treatment/care since studies have shown a clear relationship between prolonged restricted activity and the risk of failure in returning to pre-injury status. The TCA Guidelines also state that repeated use of acute care measures generally fosters chronicity, physician dependence and over-utilization and the repeated use of passive treatment/care tends to promote physician dependence and chronicity. Therefore, the medical necessity of the continuing passive treatments is not supported.

The records fail to substantiate that the disputed services fulfilled the statutory requirements ⁸ since the patient did not obtain relief, promotion of recovery was not accomplished and there was not an enhancement of the employee's ability to return to employment. A re-examination was not performed by the provider subsequent to 05/19/04 and the patient's pain rating remained constant at 6/10 on most visits. In fact, the patient's pain rating did not decrease until after (and likely the result of) the second epidural steroidal injection on 08/12/04. The claimant's lack of recovery is also documented by the surgeon's report of 10/19/04 in which he recommended lumbar surgery.

⁵ Haas M, Group E, Kraemer DF. Dose-response for chiropractic care of chronic low back pain. *Spine J.* 2004 Sep-Oct;4(5):574-83. "There was a positive, clinically important effect of the number of chiropractic treatments for chronic low back pain on pain intensity and disability at 4 weeks. Relief was substantial for patients receiving care 3 to 4 times per week for 3 weeks."

⁶ *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),

⁷ Quality Assurance Guidelines, Texas Chiropractic Association.

⁸ Texas Labor Code 408.021